Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
Phone #: **(608) 266-0145**

E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

BOARD OF NURSING

APPLICATION FOR RE-REGISTRATION OF REGISTERED NURSE LICENSE

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth

_____ _____ _____
month day year

Daytime Telephone Number

( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Primary Residence: _____ (State)
("state of primary residence" means the state of a person's declared fixed permanent and principal home for legal purposes, such as voting, driver's license, or paying taxes).

State of Original Licensure: _____

Wisconsin Original Licensure Number*: _____

Date of Expiration*: _____

***To obtain your Wisconsin original license number and expiration date go to http://drl.wi.gov.**

APPLICATION FEES (Make check payable to Department of Regulation and Licensing and attach to application).

___ $ 66.00 Re-Registration Fee
$ 25.00 Late Renewal Fee
$ 91.00 Total fee attached

For Receipting Use Only

Wisconsin Department of Regulation & Licensing

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Fee(s) attached to this application (Form #2460)

Verification of Licensure (Form #741) or letters from all state boards where licensed (includes active and inactive licenses)

Social Security Form (Page 5 of this form)

Copies of malpractice suit(s). Court documents with allegations and settlement (if applicable)

IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.

PRACTICE: Account for all activities and practice from date of expiration of Wisconsin license to the present time. **Must include professional and non-professional activities. ALL activities must be accounted for.** No more than a 3-month gap is allowed. Please include dates of unemployment. Example: stayed home to raise children, retail employment.

	NAME OF EMPLOYER / CAPACITY IN WHICH YOU ARE/WERE EMPLOYED	**LOCATION OF EMPLOYMENT (CITY / STATE)**	**DATES EMPLOYED (FROM-TO) MO/YR**
1.			
2.			
3.			
4.			

Note: If you have not had registered nurse employment within 2 years of the last 5 years, you will be issued a limited license to obtain a refresher course.

I AM LICENSED IN THE FOLLOWING STATES (UNLIMITED):

By Written Exam: _____

By Endorsement/Reciprocity: _____

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE BEEN LICENSED SINCE THE DATE OF EXPIRATION OF WISCONSIN LICENSE SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN BOARD OF NURSING. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, LICENSE NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR LICENSURE. (SUBMIT FORM #741 TO EACH STATE BOARD WHERE CREDENTIALED.)

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary.)

		YES	**NO**
1.	Are you a nurse anesthetist CRNA?	❑	❑
2.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	❑	❑
3.	Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	❑	❑
4.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? **If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.**	❑	❑
5.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	❑	❑

Wisconsin Department of Regulation & Licensing

		YES	NO
6.	Do you have any felony or misdemeanor charges pending against you? **If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)**	❑	❑
7.	Have you ever been convicted of a misdemeanor or a felony? **If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)**	❑	❑
8.	Are you incarcerated, on probation or on parole for any conviction? **If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.**	❑	❑
9.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.**	❑	❑
10.	Are you registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what states(s).**	❑	❑
11.	Have you ever been credentialed under any other name(s)? **If yes, state name(s) credentialed under.**	❑	❑

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as a registered nurse" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned nursing judgments and to learn and keep abreast of nursing developments; and
2. The ability to communicate those judgments and nursing information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform nursing tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

		YES	NO
12.	Do you have a medical condition which in any way impairs or limits your ability to practice nursing with reasonable skill and safety? **If yes, please explain.**	❑	❑
13.	Does your use of chemical substance(s) in any way impair or limit your ability to practice nursing with reasonable skill and safety? **If yes, please explain.**	❑	❑

		YES	NO
14.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? **If yes, please explain.**	❑	❑
15.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? **If yes, please explain.**	❑	❑
16.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **If yes, please explain.**	❑	❑
17.	Are you currently engaged in the illegal use of controlled dangerous substances?	❑	❑
18.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **If yes, please explain.**	❑	❑

AFFIDAVIT OF APPLICANT

I, the above-named applicant, state that I am the person referred to in this application and that all the statements herein contained are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential or other disciplinary action. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Board of Nursing or the Department of Regulation and Licensing will be cause for disciplinary action.

_____ _____

Applicant Signature Date

Subscribed and sworn to before me this _____ day of

_____ , 20 _____

_____ **SEAL**

Notary Public

_____

State

My Commission Expires:_____

NOTE: This affidavit must be signed by the applicant in the presence of the notary public on the same date.

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

_____

First Name Middle Initial Last Name

_____

Profession

Date of Birth _____ _____ _____

month day year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

[1] Section 440.03 (11m), Wis. Stats.

[2] Sections 49.22, and 440.13, Wis. Stats.

[3] Section 440.12, Wis. Stats.

[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.